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Sophia Rose Glass
It's Time to Talk about Sex and
Social Work: Why Human Sexuality
Education Matters for Social Work
Practice

ABSTRACT

This research investigated human sexuality training received in social work programs and its impact on clinical practice. Specifically, it examined clinicians' comfort and competency addressing sex and sexuality related topics with clients. 67 participants were recruited via a non-probability snowball sampling technique, and data was gathered anonymously through a secure web-based survey instrument. The findings supported the author's hypothesis that there is a substantial lack of human sexuality training in social work programs despite the finding that sexuality is highly relevant to clinical work. Barriers to social workers effectively addressing these topics with clients were identified as inadequate education and clinician discomfort. By highlighting this gap between training and practice, the study hoped to demonstrate the critical importance of comprehensive human sexuality education in social work programs.

**IT'S TIME TO TALK ABOUT SEX AND SOCIAL WORK: WHY HUMAN SEXUALITY
EDUCATION MATTERS FOR SOCIAL WORK PRACTICE**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2016

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CHAPTER I

Introduction

How do clinical social workers talk about sex and sexuality with clients? What unconscious biases are brought into clinical relationships about “normal” and “healthy” sexuality? Social work has most often approached sex and sexuality from a framework of sexual problems to be solved (Myers & Milner, 2007), rather than a salient element of pleasure and wellness in people’s lives. There is a lack of ongoing critical engagement with human sexuality in the field of social work (McCave, Shepard & Winter, 2014).

Sexuality is a term that includes many meaningful aspects of human experience and expression. The World Health Organization (2006) defines sexuality as:

A central aspect of being human [that] encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships [and] influenced by... biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors (Sexuality, para. 2).

Yet, the field of social work has historically participated in the pathologizing of many aspects of human sexuality (Myers & Milner, 2007). Where it has not been framed as a problem or pathology, sexuality has often been ignored by mental health education and practice. For instance, education on topics of human sexuality is limited in graduate level clinical training for

psychotherapists in the United States, both in courses offered and in depth of material covered (Miller & Byers, 2010). This remains the case despite research over the past several decades demonstrating a positive correlation between the amount of sexuality education received and therapists' clinical comfort and skill addressing sexuality related topics with clients (Anderson, 1986; Miller & Byers, 2010; Miller & Byers, 2012).

The absence of comprehensive sexuality education in training programs for social workers and psychologists alike is problematic given that sexuality is recognized to be an essential and integral part of a person's wellbeing, including both physical and mental health (Firestone, Firestone, & Catlett, 2006; McCave, Shepard, & Winter, 2014; Miller & Byers, 2010; Sloane, 2014). As such it should be expected that sex and sexuality be thoroughly integrated into social work education and practice. This is especially important since social workers often serve vulnerable populations who face systemic social marginalization, communities who may have limited access to education and information concerning either sexual health or pleasure (Myers & Milner, 2007).

The present research built upon existing scholarship to investigate human sexuality competency for clinical social workers. The study intended to explore social workers' attitudes regarding topics of sex and sexuality, and how related issues are addressed in clinical work. The research asked: What informs how social workers address topics related to human sexuality with clients? How and when do sex and sexuality come up in clinical settings and how do social workers respond?

My hypothesis was that a lack of human sexuality education in social work training would be a repeated theme of this study. The study aimed to expand the body of research that found a relationship between education received and clinical skills for mental health

professionals, and proposed to further explore social workers' attitudes toward working with topics of sexuality.

This study is grounded in the belief that sexuality and sexual pleasure are a healthy and essential part of human expression and experience. Sexuality and sex is understood here as a wide spectrum of human experiences, behaviors, and activities self-determined by an individual. For the purpose of this study, sexual pleasure is understood as physical, emotional and/or mental responses to sexual stimuli that are experienced as pleasurable to a consenting individual. In this context, there is no hierarchy of "normal" sexual acts or hierarchy of "normal" amount of sex to have; in fact there is no "normal." A study of sexuality must include the ways in which sexuality is controlled and regulated by social norms, impacted by social privilege and systemic oppression, and sexual violence. Individuals who choose not to engage in sexual activity are included in this discussion of sexuality, which concerns itself with deconstructing social norms and assumptions about sexuality, sex, and desire.

CHAPTER II

Literature Review

The present study is concerned with undoing the fallacy of *normal* sexuality. In this way, the study echoed the work of McCave, Shepard & Winter (2014), who call for social workers to incorporate an anti-oppression framework into discussions of sexuality by rejecting social constructs of normative sexuality. The following review is divided into three sections. The first section illustrates the ways in which social work currently enforces heteronormative frameworks of sexuality. The second section briefly reviews ways in which mental health fields have historically pathologized non-normative sexuality and sexual expression. The third section presents relevant literature on human sexuality education in the field of mental health, and describes how the current study will build upon existing scholarship.

Social Work and Enforcement of Heteronormative Gender and Sexuality

When human sexuality is incorporated into social work education, the focus is commonly on marginalized sexual orientations and gender identities such as lesbian, gay, bisexual, transgender (LGBT) populations, or on addressing public health topics such as HIV/AIDs (Dunk, 2007; McCave, Shepard & Winter, 2014). Though LGBT identities and sexual health topics are integral to human sexuality education, the ways in which they are taught do not necessarily challenge cultural norms of sexuality. For instance, LGBT competency frameworks rely on the assumption that groups always share common characteristics that can be understood, categorized, and normalized (Hicks, 2008; Myers & Milner, 2007). The utility of group identity

categories has been contested, as some argue that categories can be instruments of reproducing oppression (McPhail, 2004). For example, according to Hicks (2008), the production of knowledge about sexuality categories such as lesbian and gay maintains heterosexuality as the norm from which all others differ. In this way, heteronormative constructs are reinforced, rather than challenged. This is one example of how the social work field operationalizes identity categories rather than destabilizing the essentialism that underlie their use (McPhail, 2004).

Heteronormativity produces compulsory heterosexuality, or the assumption that heterosexuality is natural (Myers & Milner, 2007). Heteronormativity functions through the gender binary, the belief in two discrete gender categories that exist in complement to each other (McPhail, 2004). In this ideology, non-heterosexuality becomes abnormal by default (Hicks, 2008), as does gender non-conformity. Additionally, heteronormativity controls social power invested in certain types of relationships, such as favoring monogamy and marriage over alternative partnerships, and regulating the value placed on gender expressions, sexual identities, and sexual acts and behaviors. As Hicks (2008) explains, sexuality is frequently framed as a personal quality of an individual, which obscures how sexuality is regulated through cultural discourses. Social workers, as products of culture, do not escape conditioning by these doctrines.

Laumann and colleagues (1994) assert that dominant culture influences and produces human perceptions of sex and sexuality. They argue that these sexual scripts, or sexual norms, are more powerful determinants of how a person will act sexually than any biological motive. One example of sexual scripts is the naturalization of reproductive and penetrative heterosexual intercourse as the primary sexual act; as Myers and Milner (2007) write, this sexual act becomes socially sanctioned as “the template for all sexual activity, the standard by which all other sexual

acts are measured” (p. 24). As such, possibilities of sexual expression become limited by these prescriptive sexual norms.

Sexual norms always exist in relationship to social privilege and marginalization. Bodily and sexual autonomy, including development and expression of sexuality, are impacted by structural oppression and violence. Social identities, such as gender, sexual orientation, race, ethnicity, socioeconomic status, disability, age, and body-size inform cultural assumptions about sex and sexuality, and impact social access to sexual self-determination (Graham & Padilla, 2014).

Without critically examining these sexual scripts, social workers may reinforce unconscious social biases about their clients’ sexualities during treatment. For example, consensual pleasure-seeking sexual behaviors that fall outside the norm, such as kink activities (defined on page 8), may be met with misunderstanding or pathology. Those who identify as asexual, or who do not desire sexual activities, may face damaging assumptions about what constitutes a “normal” level of sexual desire (Prause & Graham, 2007). While in certain cases decreased sexual desire may be associated with mental health concerns such as depression or trauma, social workers must dismantle their assumptions that asexuality is a symptom of psychopathology (Prause & Graham, 2007).

Implicit bias in social workers is exemplified in the findings of Martinez, Barsky, & Singleton (2011), who conducted a study on social workers’ “queer consciousness.” Martinez and colleagues found that while most social workers did not demonstrate overt homophobia or prejudice, many still expressed heterosexist attitudes and values such as ideas of normal and abnormal sexuality and sexual activity. This is akin to acceptance of non-heterosexual identities only to the extent that they can be assimilated into a heteronormative understanding of sexuality.

Similarly, Harris and Hays (2008) argue that therapists' own anxieties and attitudes about sex may be a barrier to effectively addressing sexuality in the lives of their clients. As long as cultural constructs of morality normalize only certain sexual behaviors, they determine social norms of what is sexually permissible and with whom (Myers and Milner, 2007). Consequently, clinicians risk reproducing social shame and stigma that act as regulatory tools for controlling sexuality and sexual behavior (McCave, Shepard & Winter 2014).

Problems and Pathology in Mental Health Conceptualizations of Sexuality

One of the clearest examples of how the mental health field has been complicit in the pathologizing of sexuality is the classifications in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. Until 1973, homosexuality was classified as a mental health disorder. With the release of the *DSM III*, the diagnosis was replaced with the term "ego-dystonic homosexuality," which meant that an individual's distress or discontent regarding their homosexual orientation was understood as disordered, rather than the orientation itself (Martinez, 2011). This was removed from the *DSM* in 1987, determined to no longer meet the characterization of a mental disorder (Drescher, 2010). A similar pattern has emerged with gender in the most recent iteration of the *DSM*: "Gender Identity Disorder" the former diagnosis given to transgender and gender nonconforming individuals, has been amended to "Gender Dysphoria" (GD), a diagnosis applied in the case in which an individual experiences significant distress related to gender nonconformity (American Psychiatric Association, 2013). The diagnosis remains problematic, as distress may be an appropriate response to a hostile cultural environment in which transgender or gender non-conforming individuals face discrimination, social stigma, and high rates of violence. However, as Kraus (2015) writes, many see the new diagnosis as a necessary compromise between stigma and access to systems of care; a psychiatric

diagnosis is often a way for individuals to access insurance coverage for gender affirmative treatments.

The revision of the GD diagnosis may have additional problematic effects for intersex individuals. The Intersex Society of North America (1993) defines intersex as “a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn’t seem to fit the typical definitions of female or male” (para. 1). Kraus (2015) gives a historical overview of how intersex has been positioned in the different revisions of the *DSM*, finishing with the most recent *DSM V* in which “disorders of sex development” (DSD) is a specifier of GD. Kraus critiques the decision to absorb the physical condition of intersex under a psychiatric diagnosis, writing that intersex individuals might experience GD as secondary to non-consensual and invasive “normalizing” sex assignment surgeries that many are subjected to as infants. Furthermore, a GD diagnosis does not account for the subsequent healthcare needs of intersex individuals. Kraus concludes that intersex/DSD should be removed entirely from the *DSM* to decrease risk of stigma or misdiagnosis. There is a lack of critical attention paid to the mental health care needs of intersex individuals, which is reflected by limited social work scholarship addressing these topics.

The diagnoses of sexual dysfunctions in the *DSM* are also worthy of exploration. A full review of these diagnoses is beyond the scope of this thesis, however several brief examples are included. In the most current *DSM V*, diagnoses include “Female Orgasmic Disorder” and “Female Sexual Interest/Arousal disorder,” that normalize the frequency with which women orgasm or desire sex (American Psychiatric Association, 2013). As with most of the diagnoses mentioned, the description of the clinical threshold includes a client feeling distress. However, it is unclear whether this distress could be a product of anxiety due to cultural expectations about

arousal, and therefore a protective response. These diagnoses not only rely on essentialist understandings of gender, they fail to recognize the ways in which gender socialization, sexuality, and sexual desire are complex phenomena that cannot be reduced to a series of symptoms (Southern & Cade, 2011).

Stigma and myths around consensual sexual practices involving bondage, discipline, dominance, submission, sadism, and masochism (BDSM) are other examples of pathology within the mental health field (Kolmes, Stock, & Moser, 2006; Richters, de Visser, Rissel, Grulich, & Smith, 2008; Nichols, 2006). Activities involving BDSM, along with other alternative sexual interests such as fetishes (loosely defined as attraction or arousal by certain objects), are often referenced under the umbrella term “kink.” Individuals engage in kinky sexual practices for highly variable reasons related to seeking sexual pleasure, and there is no evidence to substantiate misconstructions that those who engage in BDSM are more prone to self-destructive, non-consensual, or pathological behavior than somebody engaging in non-kinky sexual activity (Nichols, 2006).

However in spite of this, “sexual masochism” and “sexual sadism” remain diagnoses under “paraphilias” in the *DSM V*. As with other diagnostic criteria, the *DSM* has shifted to include only non-consensual activity, or those who experience distress related to their sexual preference (American Psychiatric Association, 2013). Though potentially a step forward in addressing pathology of non-normative sexual activities, the continued inclusion of these diagnoses in the *DSM* reinforces hierarchies of human sexual desires and pleasures. Further, distress remains a subjective qualifier that can result from stigma and shame, as both clinicians and clients alike are subjected to myths about these sexual desires and behaviors (Nichols, 2006). Without education regarding consensual BDSM, clinicians may not have the skills or the

motivation to differentiate a client's preferred sexual expression or kink from the bias surrounding it. This is demonstrated by Kolmes, Stock and Moser (2006) in their study of 197 consumers of mental health care who engage in consensual BDSM practices. They found that over half of participants reported this sexual activity being the object of harmful bias in the therapeutic care they received. The researchers conclude that there remains a considerable need for education and training on topics of BDSM for mental health providers.

Sexuality Education and Clinical Effectiveness

Thirty years ago, Anderson (1986) found that human sexuality training among psychotherapy students increased effectiveness in sexuality-related work with clients. Contemporary researchers Miller and Byers (2010) conducted a study of 162 psychologists in Canada and the United States and found that most received minimal sexuality training, yet nearly all worked with clients whose presenting problems included issues related to sexuality. They concluded that, without relevant education, clinicians are not likely to provide effective intervention.

In a follow-up study, Miller and Byers (2011) assessed the confidence of Canadian and American psychologists when addressing sexual issues, referred to in their study as sexual intervention self-efficacy. Overall, sexuality education was positively correlated with self-efficacy and confident intervention with clients. However, they found that most therapists neither assessed for nor addressed sexuality issues routinely, suggesting low self-efficacy. A study conducted by Reissing and Giulio (2010) of 188 clinical psychologists in Canada presented similar findings; although clients regularly presented with issues related to sexuality, clinicians reported inadequate training on these topics. The majority furthermore reported they did not routinely assess for concerns related to sexual health or sexuality. The researchers concluded that

this was due to a lack of education, comfort, and familiarity with these topics. These studies illustrate how sexuality is addressed in clinical education and practice in the field of psychology. More research is needed to assess how clinical social workers attend to sexuality topics in their work with clients.

Harris and Hays (2008) conducted a study of 175 Marriage and Family Therapists to assess how clinicians approached topics of sexuality in session with clients. The study found that sexuality education was the strongest influence of whether therapists brought up topics of sexuality with clients, once again highlighting how therapist comfort is directly related to perception of sexual knowledge.

Another area of clinical work where education becomes necessary is addressing sexual feelings and attraction in therapeutic relationships, often conceptualized as erotic transference and countertransference (Book, 1995; Pope, Keith-Spiegel, & Tabachnick, 1986; Rodgers, 2011). Thoughts and feelings of attraction within clinical relationships have been found to be common (Pope, et al., 1986; Rodgers, 2011). Pope and colleagues (1986) conducted a large-scale survey of clinicians and found that the vast majority (87%) of participants reported having experienced attraction to clients, yet over half reported no education regarding this topic during their training, and only 9% reported satisfactory education. Another study by Giovazolias & Davis (2001) found that 77.9% of surveyed respondents had experienced sexual attraction to clients.

Pope and colleagues (2006) concluded that training for therapists should include how to negotiate attraction within therapeutic relationships to minimize any harm including anxiety, shame, or actual boundary violations, such as sexual engagement with clients. Nearly thirty years later, Rodgers (2011) conducted a smaller qualitative study with therapists; it was found that all

participants had experienced erotic feelings while working with clients. All expressed concern that they had not received more formal education on this topic. Rodgers (2011) asserts that training should include how a clinician might work with erotic transference in an ethical way to facilitate change with clients. Given how widespread experiences of sexual attraction are in therapeutic relationships, limiting training on these topics can have damaging effects on clinical practices.

Sexuality is also important to consider in work with individuals who have disabilities. As many as 72% of individuals with disabilities report some sexual concern; however these issues often remain unaddressed and not discussed in health care systems (Haboubi & Lincoln, 2003). Cultural norms do not position those with disabilities as sexual beings who desire or engage in sexual activity (Guldin, 2000; Quinn & Happell, 2012; Tepper, 2000). The dominant framing of individuals with disabilities as non-sexual is exacerbated by the ways in which ableism limits access to accurate and pleasure-based sexuality information (Sloane, 2014). Tepper (2000) argues that sex and sexual pleasure are issues of social accessibility for individuals with disabilities, as “full inclusion means access to pleasure” (p. 289). In this way, sexuality is understood as a critical social justice issue (Tepper, 2000).

Sloane’s (2014) research focuses on physically disabled patients in medical settings. Sloane argues that social workers must be cognizant of cultural and structural barriers to sexual pleasure, which should be regarded as a human right. This is especially essential in institutions where sexual self-determination is restricted. Sloane’s (2014) research found that clients were nervous to breach topics of sexuality with clinicians in medical settings, even when they reported sexuality being an important part of their overall health and wellbeing. Once more, this research

demonstrates that clinicians require training on how to effectively bring up sexuality and sexual pleasure with clients.

CHAPTER III

Methodology

This study was designed to investigate clinical social workers' competency and comfort working with topics of human sexuality. Specifically, the study asked the following questions: What informs how social workers address topics related to human sexuality with clients? How and when do sex and sexuality come up in clinical settings and how do social workers respond? I hypothesized that a lack of comprehensive human sexuality education in social work training programs would be a primary theme that arose during the course of this study.

Research Method and Design

A quantitative design was used for this study. Data was collected anonymously via a secure web-based survey instrument utilizing the Qualtrics platform. This design was chosen based on the following considerations: 1) a web-based survey allowed for a higher volume of participant responses than would an alternative design, such as individual interviews. 2) The survey could be distributed to a population of social workers beyond my direct network of colleagues, potentially allowing for a higher degree of generalizability.

A non-probability snowball technique was utilized for recruiting participants, and a recruitment call was sent via email and posted on the Smith Social Workers Speakeasy Facebook page, which is a page utilized by many alumni. The recruitment letter (see Appendix A) informed individuals that participation was anonymous and voluntary, as well as the purpose of the study, the sample criteria, and anticipated time commitment. Individuals were asked to

forward the invitation to their colleagues in the field who might be interested in participating.

A link to the survey was included in the calls for participants. Before beginning the survey, participants were directed to a letter of informed consent (Appendix C), which they were asked to review before indicating their consent to participate. Participants had the opportunity to print a copy of this notice.

Sample

Participants had to have successfully completed either or both a Masters of Social Work (MSW) or Bachelors of Social Work (BSW) from a program in the United States. Participants needed to be currently practicing, or practiced within the last year, clinical social work with clients. For the purposes of this study, clinical social work included individual mental health counseling, therapy, case management, and direct service work.

This inclusion criterion was determined with the assumption that social workers practicing clinical work engage in direct and individual client work. The survey instrument was designed to assess how sex and sexuality is addressed in relationships formed between social workers and clients.

Participant demographics

Participants were asked demographic questions about the following identities: gender, sexual orientation, race and ethnicity, age, and religion. In order to account for complexity and multiplicity of identities, participants were invited to select one or more options for gender, sexual orientation, race and ethnicity, and religion (Table 3.1). Therefore, though there were 67 participants, there were 71 responses recorded for sexual orientation and 68 responses recorded for religion.

For gender identity, participants were asked to select one or more from the following categories: woman, man, transgender, transman, transwoman, genderqueer or gender non-conforming, and other. In the current study, transgender includes participants who chose transgender (2, 3%), transman (1, 1.5%), transwoman (0, 0%), genderqueer and gender non-conforming (5, 7.5%), and other (0, 0%) for a total of 8 (12%). This decision was made in order to make meaningful comparison categories in later analysis (Table 3.1).

For sexual orientation, the “other” category was selected by one participant, who wrote in their orientation as “heterosexual;” this response was recoded to “straight” and the “other” category was dropped.

Participants were asked to select from the following race and ethnicity demographic options: African American or Black, Hispanic or Latin American, Asian, Native American or Alaska Native, Native Hawaiian or Other Pacific Islander, White, Multiracial, and Other. There were 64 responses. Categories not selected by any participants are not shown below in the table.

Table 3.1

Demographic characteristics of participants (N=67)

| | <u>N</u> | <u>%</u> |
|----------------------------|----------|----------|
| GENDER IDENTITY | | |
| Woman | 47 | 70.1 |
| Man | 8 | 11.9 |
| Transgender | 8 | 12 |
| Missing | 4 | 6 |
| SEXUAL ORIENTATION* | | |
| Gay | 4 | 6 |
| Lesbian | 8 | 11.9 |
| Queer | 23 | 34.3 |
| Asexual | 1 | 1.5 |
| Bisexual | 7 | 10.4 |
| Questioning | 3 | 4.5 |
| Straight | 25 | 37.3 |
| RACE AND ETHNICITY | | |
| African American or Black | 2 | 3 |
| Hispanic or Latin American | 2 | 3 |
| Asian | 1 | 1.5 |
| White | 56 | 83.6 |
| Multiracial | 2 | 3 |
| Other | 2 | 3 |
| Missing | 2 | 3 |
| AGE IN YEARS | | |
| 20-29 | 10 | 14.9 |
| 30-39 | 28 | 41.8 |
| 40-49 | 10 | 14.9 |
| 50-59 | 8 | 11.9 |
| 60-69 | 4 | 6 |
| 70+ | 2 | 3 |
| Missing | 5 | 7.5 |
| RELIGION* | | |
| Christian Protestant | 8 | 11.9 |
| Catholic | 5 | 7.5 |
| Jewish | 11 | 16.4 |
| Muslim | 1 | 1.5 |
| Hindu | 1 | 1.5 |
| Pagan | 4 | 6 |
| Atheist | 16 | 23.9 |
| Other | 22 | 32.8 |

*These categories total more than 67 due to the participants being allowed make multiple selections. The survey instrument was designed as such in order to allow for multiplicity of identities.

Data Collection and Analysis

Prior to data collection, the Human Subjects Review Board of Smith College School for Social Work approved the methodology of this study (Appendix D). Data was collected from February 11, 2016 through March 24, 2016.

As previously mentioned, data was collected through the secure web-based and anonymous survey platform Qualtrics. The survey instrument questions (see Appendix B) were divided into the following categories: education and training, clinical work, and clinician comfort and attitudes. The instrument was comprised of multiple-choice questions. Collected data was analyzed in SPSS by Marjorie Postal at Smith College School for Social Work. Univariate and bivariate analyses are used in the findings. Bivariate analyses were completed with spearman rho correlation tests.

Ethics and confidentiality

This study was anonymous, meaning there was no collection of participants' identifying information. Individuals were informed of risks of participation via the informed consent letter. Participants were told that it was possible that some of the survey content could raise uncomfortable emotions or memories; however, it was expected that such reactions should be within the range of what most social workers encounter in their clinical work. If necessary, participants were encouraged to seek additional consultation or supervision to address concerns raised by this research. The stated expectation was that participants would know how to find such resources without the help of the researcher.

CHAPTER IV

Findings

Seventy-seven social workers engaged in direct clinical social work consented to participate in the survey. Ten dropped out after consenting to participate, making the participant total 67. The results are divided into three categories: education and training, clinical competency and practice, and clinician comfort and attitudes.

Participants were provided with the following definition of sexuality before beginning the survey: *For the purposes of this study, sexuality is understood as an essential part of human experience that includes, but is not limited to: sexual activities, sexual health, sexual pleasure, sexual expression, gender and sexual identities. Sexuality is impacted by environmental and cultural influences, including social privilege, systemic oppression, and violence.*

Education and Training

Of the 67 respondents, 63 (94%) identified themselves as having a Masters of Social Work (MSW) only, 1 (1.5%) had a Bachelor of Social Work (BSW) only, and 3 (4.5%) reported having both a BSW and MSW. Sixty (89.6%) participants identified themselves as “therapist/counselor,” 3 (4.5%) identified themselves as doing “case management,” and 4 (6%) identified their position as “other.” Sixty-two participants reported the amount of years they had been practicing clinical work; 30 (48.4%) of these respondents had practiced clinical social work for 1-5 years, 17 (27.4%) had practiced for 6-15 years, and 15 (24.2%) for greater than 15 years.

As expected, a primary theme from the participant responses was the lack of education and training on topics of sex and sexuality in social work programs. Fifty-nine (88.1%) participants reported that they were not required to take any courses that specifically addressed sex and sexuality during their social work program. Seven (10.4%) were required to take one course, 1 (1.5%) participant was required to take two courses, and no respondents reported a requirement of more than two courses that specifically addressed sex and sexuality.

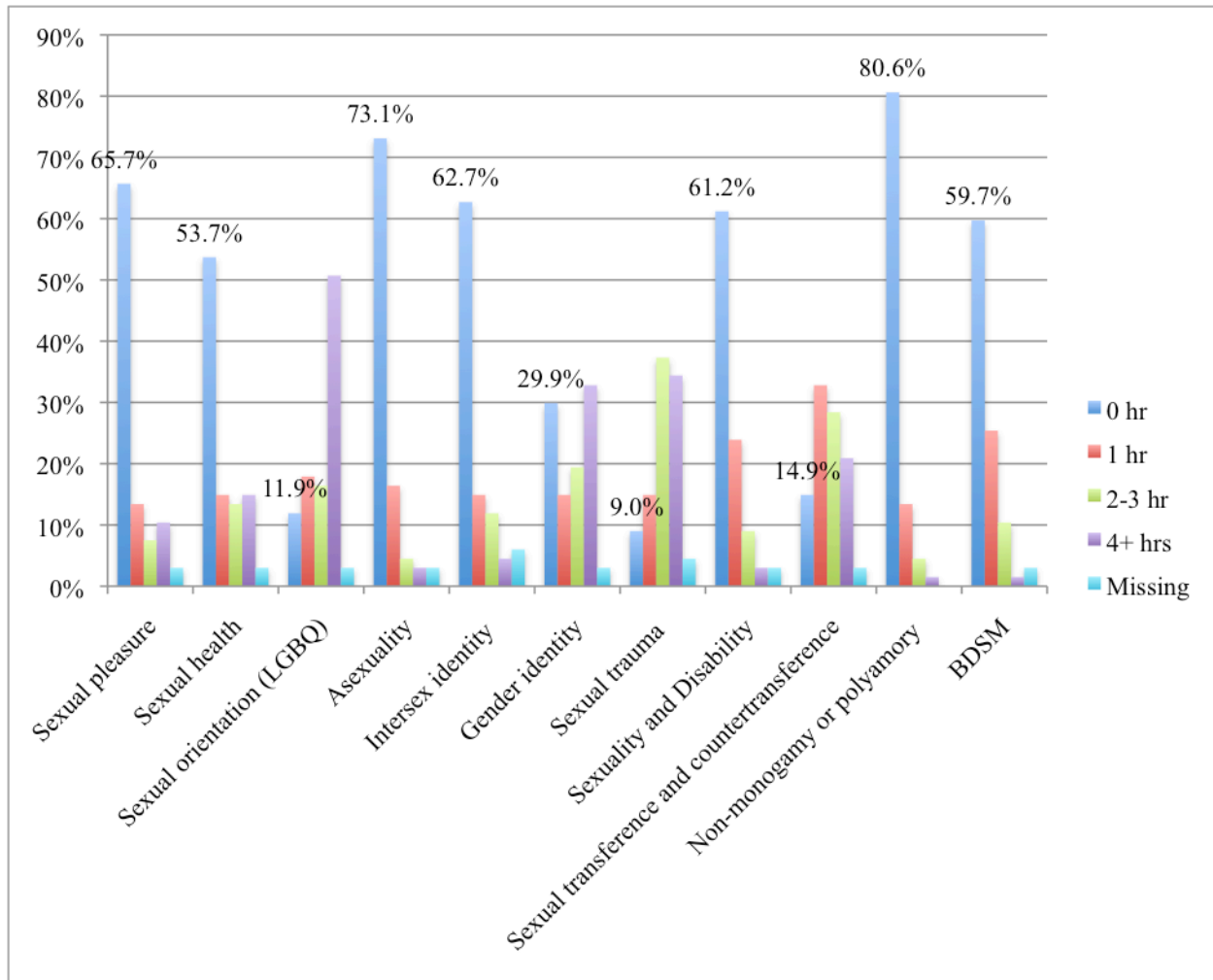
For non-required or elective courses, 44 (65.7%) respondents likewise reported taking no courses that specifically addressed sex and sexuality. Sixteen (23.9%) took one elective on sex and sexuality, and 7 (10.5%) took two or more electives. Thirty-eight (56.7%) participants felt their program had not adequately prepared them to address topics of sex and sexuality with clients. Twenty-three (34.3%) felt “somewhat” prepared by their programs, and only 6 (9%) reported feeling adequately prepared to address sexuality with clients.

Sixty-six participants responded to a question regarding additional sexuality education outside of their social work program. Of these participants, 34 (51.5%) reported receiving some education or training related to sexuality outside of their social work program, whereas 32 (48.5%) reported having received no additional education on topics of sexuality.

Figure 4.1 shows how many hours of course work the respondents received on 11 topics related to sex and sexuality. The topics are as follows: sexual pleasure, sexual health (STIs/reproductive, etc), sexual orientation (lesbian, gay, bisexual, queer identities), asexuality, intersex identity, gender identity, sexual trauma, sexuality as it relates to working with individuals with disabilities, sexual attraction within the therapeutic relationship (sexual transference and countertransference), non-monogamy or polyamory, sexual activities involving any or all of the following: bondage/ discipline, dominance/submission, sadism/masochism

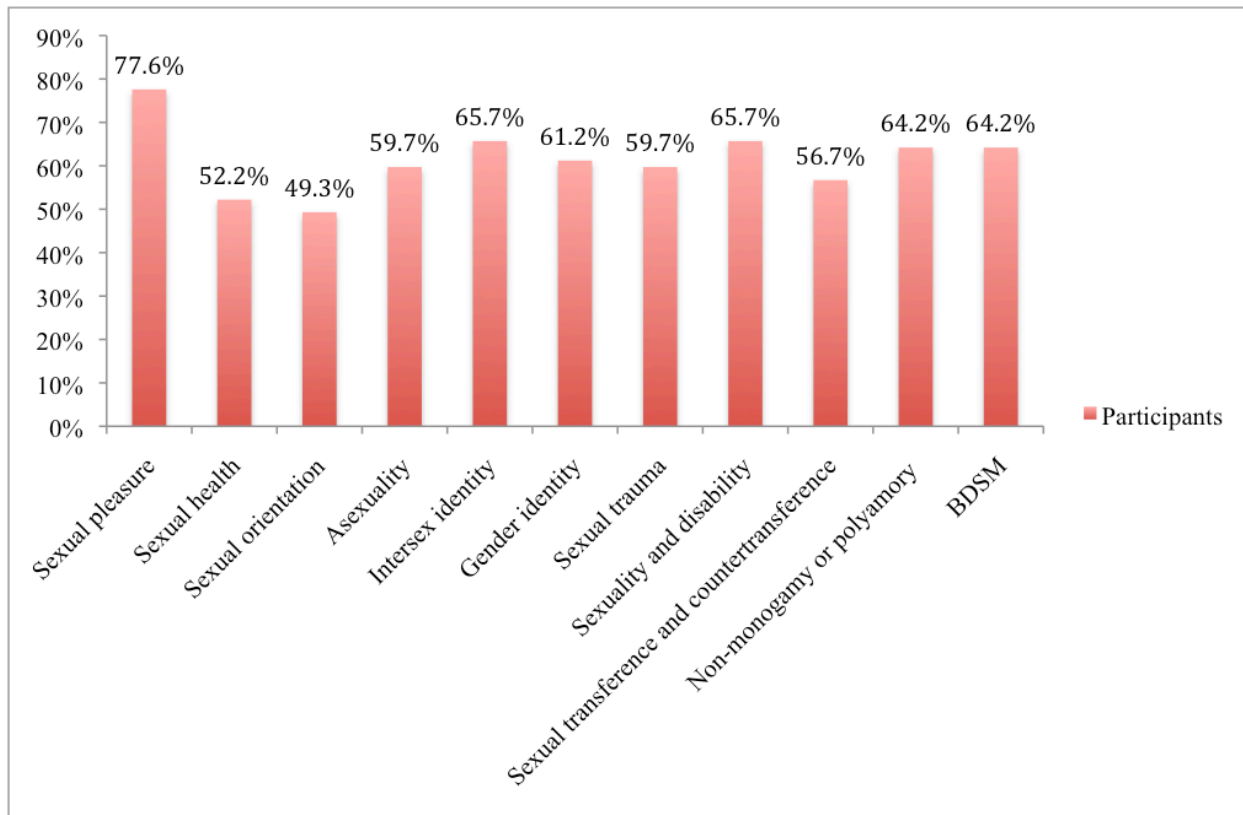
(BDSM). Figure 4.1 illustrates the percentage of respondents to receive zero hours, one hour, two or three hours, and four or more hours.

Figure 4.1: Hours of education on 11 topics of sex and sexuality (N=67)



Participants were then asked to select which of these 11 topics they would have benefitted from receiving additional education during their social work program. Figure 4.2 illustrates the responses in the percentage of total respondents who selected each topic.

Figure 4.2: Percentage of participants who reported that they would benefit from more education on 11 topics of sex and sexuality (N=67)



Clinical Competency and Practice

The survey asked participants to select one or multiple options to describe the client population(s) worked with at their current or most recent social work job. The results were: adults (47, 70.1%), adolescents (32, 47.8%), children (21, 31.3%), families (16, 23.9%), couples (14, 20.9%), other (2, 3% wrote-in “college students”). Participants’ current or most recent social work jobs were reported as follows: private practice (25, 37.3%), community mental health agency (15, 22.4%), mental health clinic (11, 16.4%), hospital or medical setting (11, 16.4%), other (6), and school system (4, 6%).

Sixty-five participants responded to a series of questions related to their clinical competency and practice. The majority of respondents reported having moderate competency, with 20 (30.8%) selecting “low to moderate,” and 32 (49.2%) selecting “moderate to high,” whereas 11 (16.9%) selected “high” competency and 2 (3.1%) selected “low” competency.

Sixty-one (93.8%) respondents said that sexuality-related topics are relevant to their clients; 34 (52.3%) reported that sexuality is “always or often” relevant, and 27 (41.5%) reported it is “somewhat” relevant, while 4 (6.2%) reported sexuality is “rarely or never” relevant to their clients. Fifty nine (90.8%) reported working with issues related to sexuality in their clinical practice; this was reported as either “always or often” (25, 37.3%) and “sometimes” (34, 50.7%). Six (9.2%) of respondents said they “rarely or never” work with issues related to sexuality with clients.

Explored further, 34 (52.3%) respondents reported they “sometimes” will initiate dialogue about sexuality with clients, whereas 22 (33.8%) responded “always or often” initiating this dialogue, and 9 (13.8%) reported they “rarely or never” bring up topics of sex and sexuality with clients. Participants were then asked if they routinely ask sexuality-related assessment questions during clinical intakes with new clients. Twenty-nine (44.6%) reported “always or often,” 21 (32.3%) reported “sometimes,” and 15 (23.1%) reported “rarely or never” asking questions related to sexuality during clinical intakes. All participants were asked to select what sexuality-related topics they address at intake. (See Table 4.1)

Table 4.1

Sexuality related topics addressed at clinical intake (N=67)

| <u>Topic</u> | <u>N</u> | <u>%</u> |
|--------------------|----------|----------|
| Sexual trauma | 53 | 79.1% |
| Sexual activity | 45 | 67.2% |
| Sexual orientation | 31 | 46.3% |
| Sexual pleasure | 11 | 16.4% |

When asked if they would bring up sexuality-related client issues with a supervisor, 26 (40%) participants responded all or most of the time, 28 (43.1%) said they would occasionally bring it up, and 4 (6.2%) said rarely or never. The remaining 9 (10.8%) did not have a supervisor.

A spearman rho correlation test was used to determine if there was a relationship between participants' responses to how relevant they interpret sexuality-related topics to be in their clients' lives and how often they reported working with topics of sexuality. There was a significant positive correlation found between these two variables ($r_s=.599$, $p=.000$), meaning that when clinicians perceived sexuality to be relevant to their clients, it was likely that they would report working on sexuality related topics with clients.

The question of relevance was also compared to how often clinicians reported initiating dialogue about sexuality-related topics with clients. Here, there was also a significant positive correlation, demonstrating that the more relevant sexuality was seen as by a clinician, the more likely they would be to initiate dialogue related to sexuality ($r_s=.440$, $p=.000$).

Lastly, the question of relevance was compared to whether clinicians assessed for sexuality-related topics with clients during intake. Once again, a significant positive correlation was found ($r_s=.444$, $p=.000$). These findings demonstrate that when clinicians perceive sexuality

to be relevant to their clients, the more likely they are to report asking about sexuality during intake.

Participants were asked a series of questions related to sexual attraction within the therapeutic relationship, i.e. sexual transference and countertransference. Of 65 participants, 39 (60%) participants reported experiencing a client express sexual attraction (erotic transference) towards them. Seventeen (26.2%) responded they had not experienced this, whereas 9 (13.8%) reported they were "unsure."

Thirty-eight (58.5%) participants reported having experienced sexual attraction (erotic countertransference) toward a client; 26 (40%) reported they had not experienced sexual attraction toward a client, and 1 (1.5%) participant reported being unsure. Participants who responded having experienced sexual attraction (either transference or countertransference) with the client were asked if they addressed this directly with the client when it had occurred. Of the 67 participants, 12 (18.5%) reported that they had addressed sexual attraction when it arose, 27 (41.5%) reported having not addressed it, 12 (18.5%) reported addressing it "some of the time," and 16 (21.5%) responded N/A.

The reasons why participants chose not to address the issue of sexual attraction with clients are illustrated in Table 4.2. Given that 27 participants reported "no," they had not addressed issues of sexual attraction in the previous question and the survey instrument read "*If you answered no to the above question, which of the following reasons resonate most closely with what stopped you from addressing it? (select all that apply),*" the number of participants for the data in Table 4.2 is reported as 27.

Table 4.2

Reasons why participants did not to address sexual attraction with client (N=27)

| <u>Topic</u> | <u>n</u> | <u>%</u> |
|--------------------------------------|----------|----------|
| Discomfort, embarrassment, shame | 14 | 51.9% |
| Lack of education and competency | 12 | 44.4% |
| Fear of crossing an ethical boundary | 10 | 37% |
| It didn't seem important | 6 | 22.2% |

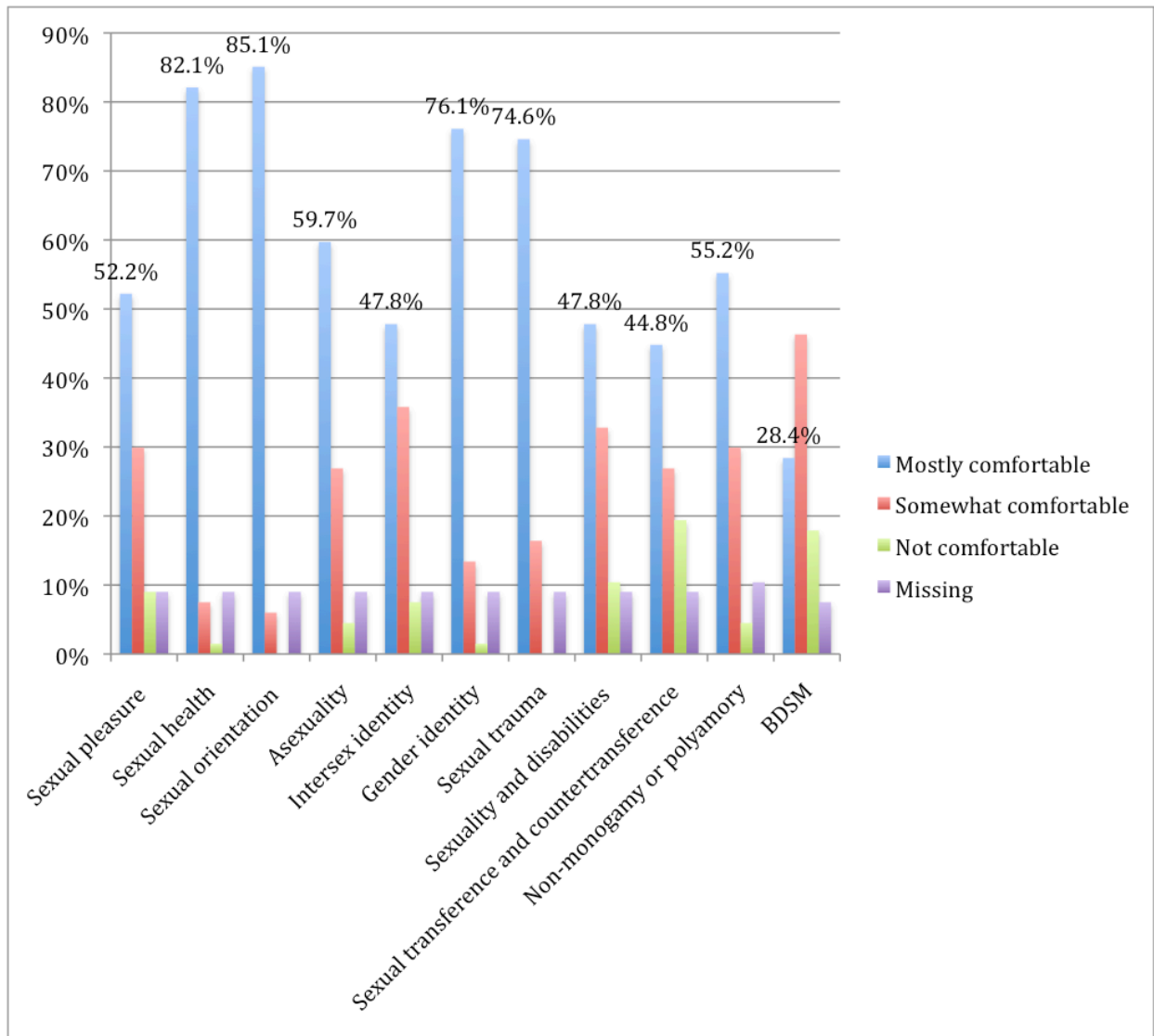
Sixty-two participants responded to a question regarding their confidence addressing sexual attraction within the social worker-client relationship; 26 (41.9%) reported feeling usually or often confident, 20 (45.2%) reported they are sometimes confident, and 8 (12.9%) felt they are rarely or never confident. Participants were asked about how the idea of sexual attraction within the social worker-client relationship (not involving a sexual encounter) made them feel: 14 (22.6%) felt mostly comfortable, 29 (46.8%) felt somewhat comfortable, and 19 (30.6%) felt uncomfortable.

Clinician Comfort and Attitudes

The study asked participants a series of questions designed to gauge participants' overall comfort and attitudes related to sex and sexuality. There were 62 responses to a question that asked participants to rate their comfort level with their own sexuality. Fifty (80.6%) reported feeling confident in their own sexuality and sexuality identity, 11 (17.7%) reported feeling sometimes confident, and only 1 (1.6%) reported rarely or never feeling confident in their own sexuality.

Respondents were asked to rate their personal comfort level working with 11 topics related to sex and sexuality. Figure 4.3 illustrates the percentages of respondents to report being “mostly comfortable,” “somewhat comfortable,” and “not comfortable” on each topic.

Figure 4.3: Participants comfort level working with 11 topics related to sex and sexuality (N=67)



A Spearman rho correlation was run to establish if hours of education on each topic of sexuality had an effect on clinicians' self-reported comfort. Due to the structure of scales in the survey, a higher score for the education variables indicated more hours per topic, whereas a higher score for comfort indicated a participant felt less comfort. Therefore, a negative correlation in this test indicates that the more hours of education received on a topic, the greater level of comfort felt by the participant on that same topic. Of the 11 topics, a significant negative correlation was found: asexuality ($r_s = -.336$, $p = .008$), intersex identity ($r_s = .385$, $p = .003$), gender identity ($r_s = -.291$, $p = .023$), sexual health ($r_s = -.272$, $p = .034$), and sexual transference and countertransference ($r_s = .368$, $p = .003$). For these topics, more education hours indicated a higher comfort level. On the following topics, no significant correlation was found between hours of education and self-reported comfort: sexual orientation, sexual pleasure, sexual trauma, sexuality and disability, and BDSM.

Sixty-two respondents replied to a question about whether they believed that sexual pleasure is relevant to social work. Fifty-nine (95.2%) of respondents agreed with the statement, only 2 (3.2%) disagreed, and 1 (1.6%) reported being unsure. Sixty-one participants reported on their beliefs regarding asking clients specific questions about sexual pleasure, 18 (29.5%) believed that it was necessary or often necessary, 40 (65.6%) believed it was sometimes necessary, and 3 (4.9%) reported feeling it was usually or always unnecessary. Sixty-five participants responded to a question about how often sexual pleasure comes up with clients, 11 (16.9%) reported "always or often," 31 (47.7%) reported "sometimes," and 23 (35.4%) reported "rarely or never."

Sixty-two participants responded to the following questions. Participants were asked if they felt comfortable discussing topics related to sexual activities with clients. 32 (51.6%)

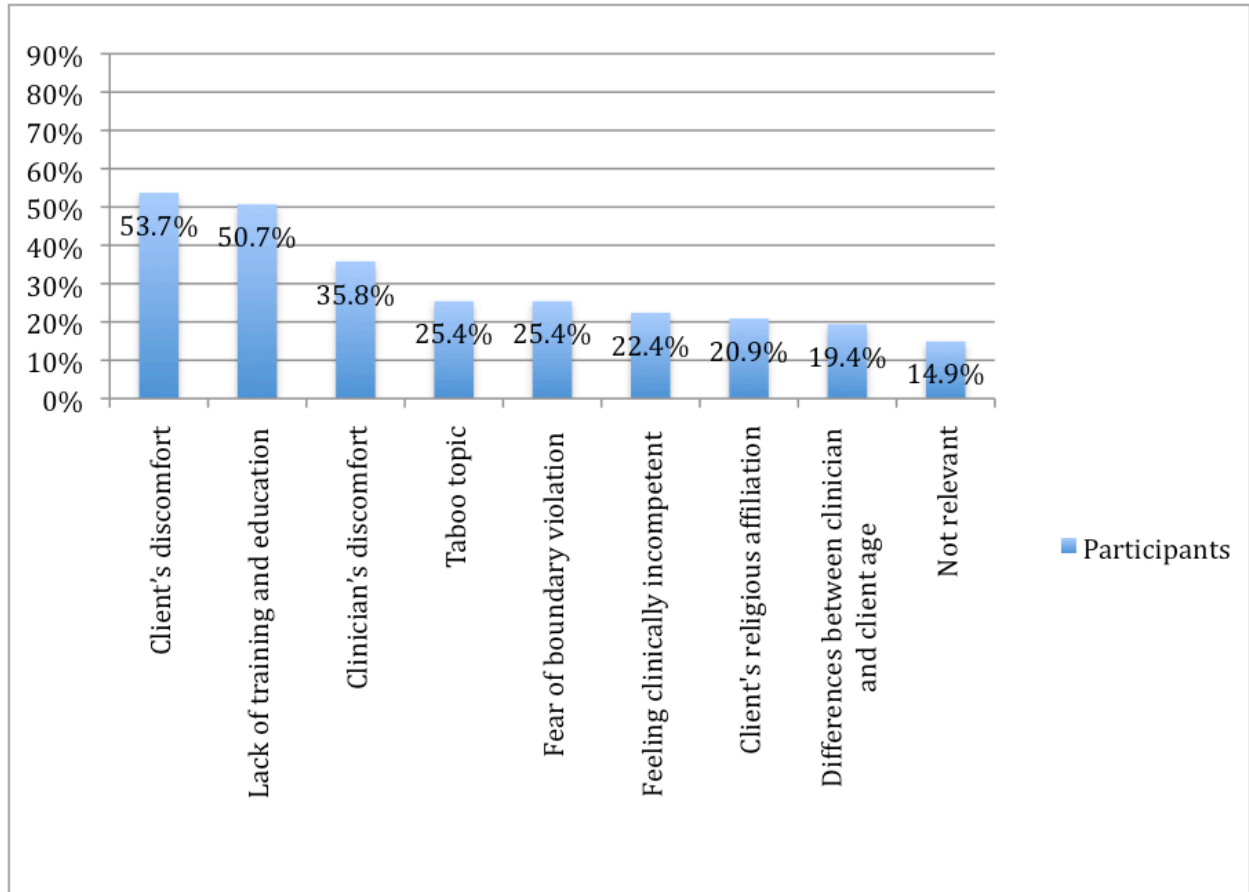
reported feeling comfortable always or more often than not, 26 (41.9%) reported feeling sometimes comfortable, 4 (6.5%) reported feeling rarely or never comfortable.

A spearman rho correlation test was run to see if clinicians' comfort in their own sexuality related to attitude and comfort discussing sexual activities and pleasure with clients. There was no significant correlation found.

Participants were asked to agree or disagree with the following statement: "I am *more likely than not* to assess for current or historical sexual abuse if my client discloses engaging in sexual activities including all or any of the following: bondage, discipline, dominance, submission, sadism or masochism (i.e. the assessment is related to the knowledge of the sexual activity). Twenty-two (35.5%) agreed, 34 (54.8%) disagreed, 6 (9.7%) were unsure. Participants were asked to gauge their feeling about a client having multiple romantic or sexual partners at the same time; 45 (72.6%) reported feeling completely or mostly comfortable, 15 (24.2%) reported feeling somewhat comfortable, 2 (3.2%) reported feeling uncomfortable.

Participants were asked to reflect on what they perceive to be the barriers to discussing sex and sexuality in their social work practice; they were invited to select all that resonated from a list of possible barriers. Figure 4.4 represents the perceived barriers that were identified most often by participants. Barriers selected fewer than 10 times are not included in Figure 4.4. They were: differences between clinician and client's sexual orientation (9, 13.4%), differences between clinician and client's ability/disability (6, 9%), differences between clinician and client's gender identity (6, 9%), differences between clinician and client's race/ethnicity (4, 6%), fear of sexual attraction within the relationship (3, 4.5%), clinician's religious affiliation (0, 0%), and there are sex therapists for that (0, 0%).

Figure 4.4: Perceived barriers to addressing sexuality related topics with clients (N=67)



CHAPTER V

Discussion

This research explored how social workers engaged in clinical practices address topics of sex and sexuality with clients. I hypothesized that the findings would indicate limited sexuality education in social work training, and wanted to investigate the subsequent impact on clinical practice. This chapter begins with a summary of major findings and relates this research to previous literature. I establish how the findings on education supported my hypothesis and discuss two additional key findings: first, how personal discomfort presents a barrier to clinicians addressing topics of sexuality with clients, and second, the discordance between social workers' perceived relevance of sexual pleasure to overall wellness, and the frequency with which it is addressed in clinical work. At the end of the chapter, I address strengths and limitations of the study, discuss implications for social work, and put forward questions to inform future research and inquiry.

Human Sexuality Education in Social Work Training Programs

A primary finding of the present research was a lack of comprehensive human sexuality education in social work programs. Although there is limited literature specifically addressing social work education on sexuality, these findings paralleled research about clinical psychology programs (Miller & Byers, 2010). The present findings indicate that social workers complete minimal coursework related to human sexuality during their training programs. In fact, nearly

ninety percent of participants reported that none of their required courses specifically addressed sex and sexuality, and the majority reported taking no electives on these topics.

As anticipated, participants reported feeling underprepared by their programs to address sexuality with clients; this is disconcerting as nearly all participants reported working with sexuality related issues in their clinical practice. The findings strongly suggested that these topics are integral to clients' lives and their presenting concerns. This echoes studies of clinical psychologists who report that, in spite of limited training in professional programs, sexuality is highly relevant to clinical practice (Miller and Byers, 2011; Reissing and Giulio, 2010).

The study identified 11 topics related to sex and sexuality to determine which topics were most likely to be addressed in social work training programs. These topics were sexual pleasure, sexual health (STIs/reproductive, etc), sexual orientation (lesbian, gay, bisexual, queer identities), asexuality, intersex identity, gender identity, sexual trauma, sexuality as it relates to working with individuals with disabilities, sexual attraction within the therapeutic relationship (sexual transference and countertransference), non-monogamy or polyamory, sexual activities involving any or all of the following: bondage/discipline, dominance/submission, sadism/masochism (BDSM). There were no topics that every participant reported receiving education on; overall participants were most likely to have completed coursework on sexual orientation, followed by sexual trauma and gender identity.

The findings support current literature indicating that sexuality in social work training most often focuses on LGBT populations (Dunk, 2007; McCave, Shepard & Winter, 2014). Training on sexual orientation and gender identity is critical for social work education. However, as previously mentioned, if this training is framed through the assumption of shared group characteristics, it can potentially reinforce gender and sexual norms. Further, positioning

sexuality as an issue that belongs to particular populations has potentially adverse effects for all clients. In order to expand these frames, social work education must critically investigate the construction and maintenance of sexual norms in order to recognize how all individuals negotiate and make meaning of sex and sexuality (Dunk, 2007); this should include an intersectional analysis of how sexuality relates to other salient aspects of self. As Hicks (2008) writes, there is a need to critically grapple with how “sexuality is produced and used within social work” (p. 72). This would better position social workers to offer anti-oppressive, culturally responsive, and affirming interventions that effectively support clients in self-determination regarding sexuality.

The findings also suggest that even for the topics where relatively more education was reported, the hours of education received were inadequate. Nearly half of those surveyed felt they would benefit from more education specific to sexual orientation. The question remains, what frameworks for sexual orientation are most useful and applicable to the lives of clients? In a discussion of expanding models of sexual behavior in therapeutic work, Iasenza (2010) writes that models approaching sexual orientation as fluid and multifaceted support clients exploring or conceptualizing their sexuality in an expansive way. Following this notion, clients are free to explore and make meaning of sexual fantasies and behaviors without imposing prescriptive cultural frameworks that might be experienced as limiting.

The majority of participants indicated that additional education on each of the identified topics would prove beneficial to their clinical practice, which suggests that clinicians want to capably address sexuality with clients. It furthermore suggests that social work programs are not supporting the educational needs of their students. Over half of participants reported having received additional sexuality education outside of their program. It is reasonable to assume that many of these participants sought out education due to lack of training in their programs.

Barriers to Welcoming Sexuality into Treatment: Client and Clinician Comfort

The findings indicate that discomfort is a primary barrier to clinicians addressing topics of sex and sexuality with clients. My hypothesis that sexuality education in social work programs increases clinician comfort was supported in the findings on the topics of sexual health, asexuality, intersex identity, gender identity, and sexual transference/countertransference. In the findings on these topics, more education hours were correlated with a higher comfort level. Therefore, one effective way to address clinician discomfort is through more comprehensive education. This is consistent with research that demonstrates that education increases mental health clinicians' confidence and comfort addressing sexual issues with clients (Miller and Byers, 2011; Reissing and Giulio, 2010; Harris and Hays, 2008).

Beyond a lack of education and training, client discomfort and clinician discomfort were named as the two greatest barriers to addressing sexuality with clients. Given that participants in the current study were clinicians rather than clients, it is impossible to know the accuracy of client discomfort as a reported barrier. In other words, since clinicians were reporting this perception of discomfort, it is possible they were projecting a degree of their own discomfort onto their clients' feelings. This is not to say that clients do not experience their own anxieties and discomfort regarding sexuality; however, it is the responsibility of a clinician to reduce this barrier by demonstrating their willingness to engage in this discussion. A clinician asking directly about sex during a first meeting opens the conversation and communicates that sexuality is seen as an important aspect of a client's life (Iasenza, 2010).

Sexual transference and sexual countertransference were both experienced by the majority of participants, which echoes literature that sexual attraction within the therapeutic relationship is a relatively common experience in clinical practice (Pope, et al., 1989; Rodgers,

2011). Though sexual transference and countertransference were topics more likely to receive training hours, clinicians reported relatively high discomfort levels addressing this directly, and many reported avoiding these issues with clients. The most reported reasons for not addressing sexual attraction were discomfort, embarrassment, or shame, lack of education and competency, and fear of crossing an ethical boundary. Though these findings point once again to inadequate education, they also confirm the role of a clinicians' own discomfort as a primary factor in how likely they are to address sexual issues with clients.

The impact of clinician discomfort was also observable in the questions relating to BDSM. Participants were most likely to indicate discomfort with BDSM compared to other topics. In a question designed to assess possible bias, nearly half of participants either agreed or were unsure that they would be more likely to assess for sexual abuse based specifically on knowledge of a client engaging in BDSM activities. Assessing for sexual trauma is arguably necessary with every client; however, there is no data to corroborate a relationship of sexual abuse to engagement in BDSM activities, and therefore this finding suggests a culturally informed assumption (Nichols, 2006). Despite recognition that those who participate in BDSM activities are no more likely to report sexual concerns than individuals engaging in other sexual activities, they often face damaging assumptions from mental health professionals (Richters et al., 2008; Nichols, 2006). This finding demonstrates that social workers may unconsciously reflect negative judgments regarding these sexual behaviors. Nichols (2006) writes that clinicians must critically reflect on their countertransference and cultural conditioning when working with clients who engage in BDSM or otherwise kinky sexual activities. Additional discomfort might be based on their own internalized shame or "fears about their own 'darker' sexual desires" (p. 299). These findings once again demonstrate the need for an expanded sexual framework and

education that supports social workers' exploring their attitudes and beliefs about sexual behaviors.

Addressing Sexual Pleasure in Social Work Practice

Another key finding was that although social workers believe that sexual pleasure is relevant to social work, it is not necessarily addressed with regularity in client relationships. Participants believed that asking clients specific questions about sexual pleasure was important, yet only a handful of participants reported sexual pleasure routinely coming up with clients. It is reasonable to assume that if social workers were regularly and directly addressing sexual pleasure, it would be a standard component of clinical practice and participants would report it coming up with more frequency.

Overall, it was found that when clinicians perceived sexuality to be relevant to their clients, it was significantly more likely that they would report initiating dialogue about sexuality and assessing for sexuality-related topics at intake with clients. This demonstrates a correlation between clinicians' overall attitudes about sexuality and how willing they are to address sexual topics in their practice. Yet, this correlation was not found for topics of sexual pleasure; for instance, though nearly all respondents felt that sexual pleasure bore relevance to their clients, addressing it at intake was much less common than assessing for other sex related topics. This finding indicates that social workers need education on sexual pleasure and incorporating sexuality as wellness into clinical practice.

Tepper (2000) illustrates how dominant culture portrayals of sexuality imagine sexual pleasure to be the "privilege" of young, white, cisgender, heterosexual, thin, and non-disabled individuals, so that "[s]exuality as a source of pleasure and as an expression of love is not readily recognized for populations that have been traditionally marginalized" (p. 285). It is necessary for

social workers to critically examine how these cultural conceptualizations of sex and pleasure might inform or reflect their own internalized assumptions or biases. I echo Sloane (2014), who writes about the importance of supporting social workers to incorporate discussions of sexual pleasure into client care. In so doing, clinicians can normalize sexual pleasure as a valid aspect of wellbeing, and welcome clients to discuss sex (Sloane, 2014).

Study Strengths and Limitations

The present research was conducted through a quantitative survey, which allowed for easy standardization and analysis of data. The survey design and scaled questions allowed for the collection of a broad range of data on diverse topics related to sexuality; it would have proven difficult to gather the same quantity of information with an alternative design.

However, a survey does not account for nuance and complexity. For example, there is specificity lost in this type of data collection, especially through subjective scales such as “always or often,” “sometimes,” “rarely or never.” Additionally there were some methodological issues in the survey design, specifically in questions where participants were allowed to select multiple answers or “select all that apply.” Though provided as an option to allow participants to express multiple viewpoints, the consequence was that the overall response rate (i.e. the total amount of participants who responded) could not be determined for these questions.

The sample also has limitations in its lack of diversity, which decreases the overall generalizability of the research. This is demonstrated by gender, race and ethnicity, and sexual orientation. The sample was overwhelmingly white. Those who identified as non-heterosexual or with marginalized sexual orientations accounted for the majority of participants. It is reasonable to assume that individuals who have sexual identities that are non-normative are more likely to have thought critically about prescriptive sexual norms than those afforded social privileges of

heterosexuality. In fact, a majority of participants reported feeling confident in their own sexuality and sexual identity, which may be related to strong sexual identity formation that comes from experiences of marginalization. Furthermore, individuals who already have an interest in sexuality may have been more willing to participate in this study.

Lastly, it is important to position myself, the researcher, as a white queer cisgender woman to recognize that much of the sample mirrors my own identities.

Implications for Social Work and Future Study

This study has important implications for social work education and practice. First, it suggests strongly that comprehensive human sexuality education must be incorporated into social work training programs in order to increase competency and reduce barriers to effective clinical work. This must include an intersectional analysis of how sexuality relates to other salient identities. It is necessary for social workers to be supported in navigating their own discomfort and exploring internalized biases and beliefs; it is crucial that clinicians recognize the influence of their own values and experiences when addressing topics of sex and sexuality (Iasenza, 2010). Social workers should consider pursuing additional educational opportunities related to sex and sexuality, as the research indicated that participants desired more education than was provided in their training programs.

It is also important for social workers to access additional resources and seek consultation around topics of sex and sexuality for clients as needed. Clinicians who practice sex therapy can be an outstanding resource for clients whose presenting problems focus on sexual issues. However, Binik and Meana (2009) warn that referring out a client to a sex therapist enables the referring clinician to position sexuality as separate from standard clinical practice, rather than integrating it into overall wellness. Social workers should gain familiarity with different

modalities practiced by sex therapists, so that they can make informed decisions to refer or seek consultation in the event that this will better serve their clients' needs.

The current research points toward ideas for future research: how might training of clinicians help them better address barriers of discomfort? How might sexual pleasure be better incorporated into social work practice? Sexuality, as demonstrated, is an essential part of an individual's life that has personal, cultural, and political importance. Without allowing for discussions of sexuality with our clients, we as social workers fall short in our ethical imperative to promote self-determination for all those we serve (NASW code of ethics, 2008; McCave, 2014). Sexuality, in all of its complexity, is an integral part of a person's right to self-determination. To disregard the importance of sexuality in the lives of clients we serve is to disregard one of social work's primary values.

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Appendix A

Participant Recruitment Letter

Dear Colleague,

My name is Sophia Glass and I am a Masters student at Smith College School for Social Work. I am currently conducting research for my thesis, which explores how human sexuality is addressed in social work education and clinical practices. This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC). Ultimately, this research may be published or presented at professional conferences.

You are being asked to participate in this study because you have successfully completed a social work degree (either BSW or MSW) in the United States, and you currently practice direct clinical social work with clients, or you have practiced within the past year. If you meet these criteria, I invite to participate in an anonymous and secure web-based survey. The survey will take about 10 minutes of your time to complete. You will be asked questions related to human sexuality, including but not limited to: training you received in your social work program, and your experience and comfort level addressing sexuality-related topics in clinical work with clients. In addition, you will be asked to complete some basic demographic questions.

This study is anonymous. There will be no collection or retaining of your identifying information. Participation in this study is voluntary. Though I cannot offer financial compensation at this time, I hope that the topic of the study will peak your interest to participate. You will be contributing valuable information to the study of how of human sexuality is currently addressed in the social work. Please forward this email along to any colleagues you feel might be interested in contributing to this study.

Thank you so much for your time and consideration.

Sophia Glass, MSW Candidate 2016

Appendix B

Survey Instrument

For the purposes of this study, sexuality is understood as an essential part of human experience that includes, but is not limited to: sexual activities, sexual health, sexual pleasure, sexual expression, gender and sexual identities. Sexuality is impacted by environmental and cultural influences, including social privilege, systemic oppression, and violence.

I. Education and Training

1. I have a:
 - a. Bachelor of Social Work (BSW)
 - b. Master of Social Work (MSW)
 - c. Both

2. Please identify the primary type of direct clinical social work you practice in your current (or most recent) role as a social worker
 - a. Therapist/Counselor
 - b. Case management
 - c. Other

3. In your MSW and/or BSW program, how many *required* courses did you take that specifically addressed human sexuality (stated as the primary course topic)?
 - a. 0
 - b. 1
 - c. 2
 - d. 3 or more

4. In your MSW and/or BSW program, how many *elective (non-required)* courses did you take that specifically addressed human sexuality (stated as the primary course topic)
 - a. 0
 - b. 1
 - c. 2
 - d. 3 or more

5. In your opinion, did your MSW and/or BSW program adequately prepare you to address client concerns related to sexuality?
 - a. Yes
 - b. Somewhat
 - c. No

6. How many total **hours** of instruction did you receive on the following topics related to human sexuality during your social work program (please round up)

Sexual Pleasure

- a. 0
- b. 1
- c. 2-3
- d. 4 or more

Sexual Health (STIs/Reproductive, etc)

- a. 0
- b. 1
- c. 2-3
- d. 4 or more

Sexual orientation (Lesbian, gay, bisexual, queer identities)

- a. 0
- b. 1
- c. 2-3
- d. 4 or more

Asexuality

- a. 0
- b. 1
- c. 2-3
- d. 4 or more

Intersex identity

- a. 0
- b. 1
- c. 2-3
- d. 4 or more

Gender identity

- a. 0
- b. 1
- c. 2-3
- d. 4 or more

Sexual trauma

- a. 0
- b. 1
- c. 2-3
- d. 4 or more

Sexuality as it relates to working with individuals with disabilities

- a. 0
- b. 1
- c. 2-3

- d. 4 or more

Sexual attraction within the therapeutic relationship (sexual transference and countertransference)

- a. 0
- b. 1
- c. 2-3
- d. 4 or more

Non-monogamy or polyamory

- a. 0
- b. 1
- c. 2-3
- d. 4 or more

Sexual activities involving any or all of the following: bondage/discipline, dominance/submission, sadism/masochism

- a. 0
- b. 1
- c. 2-3
- d. 4 or more

- 7. Have you received any *education or training* outside of your MSW and/or BSW program that specifically addressed human sexuality (stated as the primary topic)?
 - a. Yes (If Yes, briefly state topic/s covered _____)
 - b. No

- 8. Based on your clinical experience, on which of the following topics related to sexuality would you have benefited from receiving additional education during your MSW or BSW program (please mark all that apply):

- Sexual pleasure
- Sexual health (STIs/Reproductive, etc)
- Sexual orientation (lesbian, gay, bisexual, queer identities)
- Asexuality
- Intersex identity
- Gender identity
- Sexual trauma
- Sexuality as it relates to working with individuals with disabilities
- Sexual attraction within the therapeutic relationship (sexual transference and countertransference)
- Non-monogamy or polyamory
- Sexual activities involving any or all of the following: bondage/discipline, dominance/submission, sadism/masochism

II. Clinical Work

9. Please rate your *overall* current competency working with issues of sexuality in your direct clinical social work practice
 - a. High competency
 - b. Moderate to high competency
 - c. Moderate to low competency
 - d. Low competency

10. In your experience, how relevant are sexuality-related topics to the lives of your clients and their presenting concerns?
 - a. Always or often relevant
 - b. Somewhat relevant
 - c. Rarely or never relevant

11. How often do you work with issues related to sexuality in your social work practice?
 - a. Always or often
 - b. Sometimes
 - c. Rarely or never

12. How often do you initiate dialogue about topics related to sexuality with clients in your social work practice?
 - a. Always or often
 - b. Sometimes
 - c. Rarely or never

13. During an average clinical assessment of a client at intake, how often do you ask questions related specifically to sexuality?
 - a. Always or often
 - b. Sometimes
 - c. Rarely or never

14. During an average clinical assessment of a client at intake, which of the following topics do you address (check all that apply)?
 - Sexual trauma
 - Sexual activity
 - Sexual health (STIs/Reproductive health)
 - Sexual pleasure
 - Sexual orientation
 - None of the above

15. If/when issues related to sexuality come up with a client, how likely are you to talk about it with a supervisor?
 - a. All or most of the time
 - b. Occasionally
 - c. Rarely or never
 - d. I do not have a supervisor

16. How often do issues related to sexual pleasure come up with clients?
- Always or often
 - Sometimes
 - Rarely or never
17. Have you ever had a client express sexual attraction toward you (erotic transference)?
- Yes
 - No
 - Unsure
18. Have you ever experienced sexual attraction toward a client (erotic countertransference)?
- Yes
 - No
 - Unsure
19. When you have encountered sexual attraction within the clinical relationship (either erotic transference *or* erotic countertransference), did you address it with the client?
- Yes
 - No
 - Some of the time
 - N/A
20. *If you answered no to the above question*, which of the following reasons resonate most closely with what stopped you from addressing it? (select all that apply)
- Discomfort, embarrassment, or shame
 - Fear of crossing an ethical boundary
 - Lack of education and competency
 - It didn't seem important
 - N/A
21. When you have encountered sexual attraction within the clinical relationship (either erotic transference *or* erotic countertransference), did you address it with a supervisor?
- Yes
 - No
 - Some of the time
 - N/A
22. *If you answered no to the above question*, which of the following reasons resonate most closely with what stopped you from addressing it? (select all that apply)
- Discomfort, embarrassment, or shame
 - Fear of crossing an ethical boundary
 - Lack of education and competency
 - It didn't seem important
 - I don't have a supervisor

- f. N/A
- 23. Have you ever had a sexual encounter (kissing, sexual touching, dirty or fantasy talk, oral or penetrative sex) with a client?
 - a. Yes
 - b. No
 - c. I do not feel comfortable answering this question

III. Clinician Comfort and Attitudes

- 24. I am confident in my own sexuality and sexual identity
 - a. Always or more often than not
 - b. Sometimes
 - c. Rarely or never
- 25. *Sexual pleasure* is relevant to social work
 - a. Agree
 - b. Disagree
 - c. Unsure
- 26. Asking clients specific questions about sexual pleasure is
 - a. Necessary or often necessary
 - b. Sometimes necessary
 - c. Usually or always unnecessary
- 27. I feel comfortable discussing topics related to sexual activities with clients
 - a. Always or more often than not
 - b. Sometimes
 - c. Rarely or never
- 28. I am *more likely than not* to assess for current or historical sexual abuse if my client discloses engaging in sexual activities including all or any of the following: bondage, discipline, dominance, submission, sadism or masochism (i.e. the assessment is related to the knowledge of the sexual activity)
 - a. Agree
 - b. Disagree
 - c. Unsure
- 29. I feel _____ with the idea of client choosing to have multiple romantic or sexual partners at the same time
 - a. Completely or mostly comfortable
 - b. Somewhat comfortable
 - c. Not comfortable
- 30. As a social worker, there is a *higher risk* of crossing an ethical boundary when talking with clients about sex and sexuality than other topics
 - a. Agree

- b. Disagree
 - c. Unsure
31. Discussions of sexual pleasure with clients *often* lead to sexual attraction between a social worker and client
- a. Agree
 - b. Disagree
 - c. Unsure
32. I feel confident addressing issues of sexual attraction if they arise with clients
- a. Usually or often
 - b. Sometimes
 - c. Rarely or never
33. The idea of sexual attraction (not involving a sexual encounter) within a social worker-client relationship make me feel
- a. Mostly comfortable
 - b. Somewhat comfortable
 - c. Not comfortable
34. Please rate your *personal comfort level* on discussing the following topics with clients if they were to come up in your clinical work

Sexual pleasure

- a. Mostly comfortable
- b. Somewhat comfortable
- c. Not comfortable

Sexual Health (STIs/Reproductive, etc).

- a. Mostly comfortable
- b. Somewhat comfortable
- c. Not comfortable

Sexual Orientation (Lesbian, gay, bisexual, queer identities)

- a. Mostly comfortable
- b. Somewhat comfortable
- c. Not comfortable

Asexuality

- a. Mostly comfortable
- b. Somewhat comfortable
- c. Not comfortable

Intersex identity

- a. Mostly comfortable
- b. Somewhat comfortable

- c. Not comfortable

Gender Identity

- a. Mostly comfortable
- b. Somewhat comfortable
- c. Not comfortable

Sexual trauma

- a. Mostly comfortable
- b. Somewhat comfortable
- c. Not comfortable

Sexuality as it relates to working with individuals with disabilities

- a. Mostly comfortable
- b. Somewhat comfortable
- c. Not comfortable

Sexual activities involving any or all of the following: bondage/disciple, dominance/submission, sadism/masochism

- a. Mostly comfortable
- b. Somewhat comfortable
- c. Not comfortable

Non monogamy or polyamory

- a. Mostly comfortable
- b. Somewhat comfortable
- c. Not comfortable

Sexual attraction within the therapeutic relationship (sexual transference and countertransference)

- a. Mostly comfortable
- b. Somewhat comfortable
- c. Not comfortable

35. Some possible barriers to discussing sex and sexuality in my social work practice are (please select all that apply)

- Taboo topic
- My discomfort
- My client's discomfort
- Lack of training and education
- My religious affiliation
- My client's religious affiliation
- Fear of sexual attraction within the relationship
- Fear of boundary violation
- It is not relevant
- Feeling clinically incompetent

- Differences in mine and client's gender identity
- Differences in mine and my client's sexual orientation
- Differences in mine and my client's race/ethnicity
- Differences in mine and my client's age
- Differences in mine and my client's ability/disability
- There are sex therapists for that

IV. Demographic Info (select all that apply)

36. Gender identity

- a. Woman
- b. Man
- c. Transgender
- d. Trans man
- e. Trans woman
- f. Gender queer or gender non-conforming
- g. Other _____

37. Sexual orientation

- a. Gay
- b. Lesbian
- c. Queer
- d. Asexual
- e. Bisexual
- f. Questioning
- g. Straight
- h. Other _____

38. Race/Ethnicity

- a. African American or Black
- b. Hispanic or Latin American
- c. Asian
- d. Native American or Alaska Native
- e. Native Hawaiian or Other Pacific Islander
- f. White
- g. Multiracial
- h. Other _____

39. Religion

- a. Christian protestant
- b. Catholic
- c. Jewish
- d. Muslim
- e. Hindu
- f. Pagan
- g. Atheist
- h. Other _____

40. Age
- a. 20-29
 - b. 30-39
 - c. 40-49
 - d. 50-59
 - e. 60-69
 - f. 70+
41. Years as a social worker (direct clinical work with clients)
- a. 1-5
 - b. 6-10
 - c. 11-15
 - d. 16-20
 - e. 21+
42. Population primarily worked with during your current or most recent social work job
- a. Adults
 - b. Adolescents
 - c. Children
 - d. Families
 - e. Couples
 - f. Other _____
43. My current or most recent social work job:
- a. Community mental health agency
 - b. Mental health clinic
 - c. Private practice
 - d. School system
 - e. Hospital or medical setting
 - f. Other _____

Thank you for taking this survey! *Please take a moment below to provide optional feedback about your experience taking this survey*

44. Taking this survey made me feel (Please check all that apply):
- Interested
 - Comfortable
 - Uncomfortable
 - Thoughtful
 - Reflective
 - Annoyed
 - Angry
 - Confused
 - Curious
 - Other _____

Appendix C

Informed Consent

Dear Participant,

My name is Sophia Glass and I am a Masters student at Smith College School for Social Work. I am currently conducting research for my thesis, which explores how human sexuality is addressed in social work education and clinical practices. This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC). Ultimately, this research may be published or presented at professional conferences.

You are being asked to participate in this study because you have successfully completed a social work degree (either BSW or MSW) in the United States, and you currently practice direct clinical social work with clients or you have practiced within the past year. If you meet these criteria, I invite you to participate in this anonymous and secure web-based survey. I ask that you read this form and ask any questions that you may have before agreeing to be in this study.

If you consent to be a participant for this study, it will take about 10 minutes of your time to complete the survey. You will be asked questions related to human sexuality, including but not limited to: training you received in your social work program, your experience and comfort level addressing sexuality-related topics with clients, and sexual attraction and behavior with clients. In addition, you will be asked to complete some basic demographic questions.

This study is anonymous. There will be no collection of identifying information of any participant. All research materials including data, analysis, and consent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

The questions in this study are meant to offer the participant an opportunity for honest and thoughtful reflection about how topics related to sex and sexuality are addressed in their clinical practice. It is possible that the questions asked could raise uncomfortable emotions or memories. However, it is expected that such reactions should be within the range of what most social workers encounter in their clinical work. If necessary, participants are encouraged to seek additional consultation or supervision to address concerns that are raised by this research. It is expected that participants will know how to find such resources without the help of the researcher.

If you participate, you will be contributing valuable information to the study of how of human sexuality is currently addressed in the social work. Participation is voluntary and there is no penalty for withdrawing from the study. You may choose not to answer any question. However, as the study is anonymous, it will not be possible to withdraw after submitting your responses.

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Sophia Glass, at sglass@smith.edu. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Selecting "I consent to participate in this study" below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. Please print a copy of this consent form for your records.

Appendix D

Human Subjects Review Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-
7994

January 2, 2016

Sophia Glass

Dear Sophia,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,



Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Adam Brown, Research Advisor

Appendix E

Human Subjects Review Amendment Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 22, 2016

Sophia Glass

Dear Sophia,

I have reviewed your amendment and it looks fine. The amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Adam Brown, Research Advisor